An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0282
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - late notification Failure to process instructions Poor wording/ambiguity of policy
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint arises from the Provider declining the Complainant's claim under his health insurance policy due to limitation periods for medical expenses.

The Complainant's Case

The Complainant incepted his health insurance policy with the Provider on **1 December 2018**. His policy period runs from 1 December to 30 November of the following year.

In early **December 2020** the Complainant logged onto the Provider's online portal to submit his claims for **2019 (**December 2018 – November 2019) and **2020** (December 2019 – November 20202). He submitted his claims for **2020** but found that the system did not allow him to do so for the **2019**. And he received the online message:

"*The claims must be submitted within six months of the end of the year policy*."

The Complainant subsequently received an email dated **4 December 2020** headed "Your claim has been paid". When the Complainant logged in to check what payment had issued, he discovered that a claim to the value of €50 (fifty euro) for **2020** had been rejected. The Complainant noted that this rejection was not mentioned in the email correspondence and he states that:

> "*I consider this another example of* [the Provider] *deliberately misleading their customers in order to avoid paying them for legitimate claims so that it, again, slips under the radar*."

He contacted the Provider asking that his **2019** claim be facilitated, as he asserted that he had not received a clear notification that his claims had to be submitted within six months of the end of year's policy. He said that the amount of money that he was due to be refunded was approximately €200 (two hundred) a sum which the Complainant states was too large to let pass, on the basis that the deadline for its refund had passed.

Finally, he submitted that there should be some relaxation in deadlines given the effect of COVID-19:

> "*In light of the chaos that COVID-19 has played this year including countless deadline extensions by both private companies and government bodies, can the cutoff be relaxed*?"

In correspondence to the Complainant dated **10 December 2020,** the Provider declined the Complainant's claim because receipts were not submitted within six months of the end of policy year, and it also highlighted that it had sent an email reminder to the Complainant to submit his relevant health claim for the applicable period.

The Complainant contended in his letter to this Office dated **11 December 2020** that the deadline is:

> "*outlined in my policy handbook… around a third way down on page 7 of the 48 page handbook (attachment 2). Given that one of the main purposes of having health insurance is to have support in recuperating some of the costs of day-to-day medical expenses, I would consider this critical piece of information to be buried sufficiently and intentionally to be overlooked/ missed by their customers*."

In his correspondence he also comments on the reminder email sent by the Provider on **14 May 2020**:

> "*Whilst I did receive an e-mail in advance at the cutoff date (attachment 3), you will notice that it in no way highlights that an urgent deadline (worth quite a substantial figure; €200) is looming. The email sent has been worded in such a way as to not highlight any urgency that a deadline was approaching, but rather a carefully phrased correspondence to cover themselves whilst deliberately not bringing the necessary attention to the customer of the impending deadline*."

He further submits in regard to this reminder email:

> *"… There is no reason why this information could not or should not have been provided within this email to highlight the urgency of the deadline. I would like to bring your attention to attachment 3. This is an email I received from [the Provider] on 10-Mar-2021. This email contains the following wording in bold font:*

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"(Don't forget your deadline for all receipts from 2020 policy year is 31/ 05/2021)"

"I would like to highlight that this wording has been added in bold font, when previously it was not even stated."

The Complainant, in a submission to this Office on **6 October 2021**, queries how the Provider can assert that its "*records show*" that he opened the reminder email on **3 November 2020**. He states that this "*cannot be true*".

The Complainant wants the Provider to allow him to submit his claims to reclaim his medical expenses allowable under the policy for the **December 2018 – November 2019** period, and also the additional declined fee from the policy year **December 2019 – November 2020**.

The Provider's Case

The Provider issued a Final Response Letter on **10 December 2020** stating that the six-month limitation period came into effect on **1 November 2018** and applies to policies which were renewed or were started for the first time, on or after this date.

The Provider relies on the Membership Handbook which it says was issued to the Complainant and sets out the terms and conditions of the policy.

The Provider's Final Response Letter draws attention to section 2.1 of the Membership Handbook which states that receipts must be submitted within six months of the end of the Complainant's policy year.

The Provider states that a reminder email was sent on **14 May 2020**. It states that, whilst **1 June 2020** was not specifically "*called out*" in in the communication, the communication "*clearly stated that claims could only be made up to 6 months after the renewal date*".

The Provider also submitted that it has since moved away from emails as the primary method of reminding members of the six-month claiming deadline. On **2 December 2020**, after the Complainant's **December 2020** renewal, the Provider submits that it sent an SMS to the mobile telephone number of the Complainant, it "*had on file*".

The Provider further states that on **28 November 2020**, the Complainant submitted several receipts for processing. However, "*one of the receipts … did not contain enough detail for* [the Provider] *to process the claim*". The Provider asserts that because the claims agent was unable to decipher the treatment received, and the benefit under which to process the receipt, the claim was declined.

A claim settlement letter was made available to the Complainant on his online member area on **4 December 2020** noting the claim for treatment on **14 February 2020** had been declined. The Complainant resubmitted his receipt on **7 December 2020**, however, "*as no further information had been provided on the receipt in order to process the claim, it was once again*

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declined". The declinature letter dated **10 December 2020** was identical to the terms of the Provider's Final Response Letter dated **2 December 2020**.

The Provider's declinature letter dated **10 December 2020** was sent rejecting the claims. The Provider states that, because the Complainant's "*claim submission was outside the 6-month cut off, the claim was not assessed*". The Provider states that:

> "*It would be misleading to offer an appeal in this case as this rule applies to all members and must be applied consistently*."

The Complaint for Adjudication

The complaint is that the Provider in early **December 2020** wrongfully declined the Complainant's claim under his health insurance policy, for 2019 medical expenses and one receipt from 2020.

The Complainant says that the Provider poorly communicated the applicable limitation periods to reclaim allowable medical expenses, by failing to advise the Complainant of them, and by failing to make the relevant terms and conditions of the policy sufficiently clear.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainant was given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision, I have carefully considered the evidence and submissions put forward by the parties to the complaint. Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on **29 July 2022**, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter. In the absence of additional

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submissions from the parties, within the period permitted, the final determination of this office is set out below.

I note that the Complainant's policy covers "*Public, Private & High Tech*" hospitals. This policy was incepted on **1 December 2018** as part of a group scheme arranged by the Complainant's employer. I note that at the inception of the policy, the Membership Handbook was provided to the Complainant by letter dated **21 December 2018.**

Section 2.1 of the Membership Handbook deals with "Day-to-Day and Out-Patient Benefits" and under the heading "How to Claim" it states:

> "***You** must submit **your** receipts within six months of the end of **your** policy year. If **your** receipts are not received within the six months of **your** claim will not be paid.*"

I note that the Complainant submitted claims for **2019 (December 18 – November 19)** in **November 2020**, but these were rejected due to the six-month time period, having already passed. He emailed the Provider on **28 November 2020** raising the rejection.

The Provider replied on **30 November 2020** stating that because he had not submitted the claim for expenses within the six-month timeline, he would not be paid. This email also referred to the Membership Handbook.

I am satisfied on the evidence, that pursuant to section 2.1 of the Membership Handbook, the Provider was entitled to reject the **2019** claim because it was not submitted within the required 6-month timeframe set out in the Rules of Membership.

Turning to the rejection of a portion of the **2020** claim, I note that Provider has stated that the receipt for treatment on **14 February 2020**, which was submitted on two occasions, "*did not contain enough detail for [the Provider] to process the claim*".

I note that section 2.1 of the Membership Handbook states that:

> "*you should keep your original receipts for your own records and in case the images are unclear and we request them to be resubmitted*.
> *Please ensure that all receipts state;*
> - *The amount paid*
> - *The full name of the member receiving treatment and their date of birth*
> - *The date the treatment was received*
> - *The type of practitioner that you attended*
> - *The name, address and qualifications of the practitioner providing the care on the practitioner's headed paper*."

The Provider in a letter dated **11 December 2020** stated that the reason for the declinature was "*Incomplete receipt not accepted*" and then stated:

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> "*This receipt does not meet our criteria for receipts. Please submit a new receipt. For full information see the "How to Claim" section in the membership handbook*".

I have reviewed the receipt in question dated **14 February 2020** and note that it does not include the type of practitioner attended, or the name, address and qualifications of the practitioner providing the care on the practitioner's headed paper.

The Provider is required to comply with the Consumer Protection Code 2012 (the CPC 2012). Provision 7.19 of the CPC 2012 states that:

> "*If the regulated entity decides to decline the claim, the reasons for that decision must be provided to the claimant on paper or on another durable medium."*

Therefore, I am satisfied the Provider was entitled to reject the **2020** claim pursuant to section 2.1 of the Membership Handbook and that it properly communicated the reason for the rejection, in line with Provision 7.19 of the CPC 2012.

Communication of the applicable time limits

The Provider states that, on **14 May 2020**, a reminder email was sent to the Complainant regarding the period to claim, stating:

> "*Now could be a good time to submit your everyday health expense receipts. Simply take a photo and upload them through our **website** or through our member app – download the app below. You can claim expenses covered on your Plan up to 6 months after your renewal date*."

I note that the Provider has submitted to this Office on **24 September 2021** that:

> "*Our records show that the Complainant did not open this email until 3rd November at 21:01*"

The Provider later contended in a further submission to this Office on **20 October 2021** that:

> *"We can see that the Complainant opened the mail on 3rd November 2020, meaning that the images in the mail were downloaded on this date. The Complainant may have opened the mail prior to this without downloading the images (as he has demonstrated in his Attachment 1)."*

Accordingly, though I accept that the email was indeed sent on **14 May 2020**, the Provider cannot say with any certainty when it was first opened or read by the Complainant. Neither can it say, as it previously suggested, that the Complainant" *did not open this email until 3rd November".* I am satisfied however, that the Provider sent the email in question to the Complainant, its policyholder, on **14 May 2020.** Once that email had been sent, the time when the Complainant would open and consider the contents was entirely beyond the Provider's control. In my opinion, the practice of the Provider to issue a reminder to the

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Complainant, as its policyholder, was a welcome one, and it was a matter for the Complainant to consider the information being shared by the Provider, and take the necessary action, as required.

I also note that the Provider says that in an updated practice, it sent an SMS message to the mobile phone of the Complainant on **7 December 2020** which stated:

> "*Now could be a good time to submit your everyday health expense receipts. Simply take a photo and upload them through our website or through our member app – download the app below. You can claim expenses covered on your Plan up to 6 months after your renewal date."*

In my opinion, the introduction this more recent practice is also a welcome development, in communicating helpful information to the Provider's policyholders.

Provisions 4.1 and 4.2 of the CPC 2012 state:

> "4.1 *A **regulated entity** must ensure that all information it provides to a **consumer** is clear, accurate, up to date, and written in plain English. **Key information** must be brought to the attention of the **consumer**. The method of presentation must not disguise, diminish or obscure important information.*
>
> *4.2 A **regulated entity** must supply information to a **consumer** on a timely basis. In doing so, the **regulated entity** must have regard to the following:*
> *a) the urgency of the situation; and*
> *b) the time necessary for the **consumer** to absorb and react to the information provided*."

I note that the Provider states that due to COVID-19 "*there was an initial extension provided for impacted policies for a period of time up to 10th August 2020 for members whose six-month cut-off date was in either June or July 2020*". It is unclear from the evidence whether or not COVID-19 had any impact on the Complainant's ability to submit his medical expenses claim, but in any event, I note that he only submitted his claims in **November 2020**, after this extension deadline had already passed.

In conclusion, I am satisfied that the Provider was entitled to reject the **2019** claim and part of the **2020** claim for the receipt dated **14 February 2020**. The Provider was clearly entitled to reject these claims under the provisions set out at section 2.1 of the Membership Handbook, and I am satisfied that it communicated clearly to the Complainant regarding the reasons why these parts of his claims had been declined.

As there is no evidence of any wrongdoing on the part of the Provider, I do not consider it appropriate to uphold this complaint.

Conclusion

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My Decision, pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** is that this complaint is rejected.

The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.

MARYROSE MCGOVERN
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN (ACTING)

23 August 2022

PUBLICATION

Complaints about the conduct of financial service providers

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will **publish legally binding decisions** in relation to complaints concerning financial service providers in such a manner that—

(a) ensures that—

(i) a complainant shall not be identified by name, address or otherwise,

(ii) a provider shall not be identified by name or address,

and

(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.

Complaints about the conduct of pension providers

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will **publish case studies** in relation to complaints concerning pension providers in such a manner that—

(a) ensures that—

(i) a complainant shall not be identified by name, address or otherwise,

(ii) a provider shall not be identified by name or address,

and

(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.